POC acc. 5/24/06 Letter on file

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295050	A. BUILDING _____ B. WING _____	C 05/02/2006

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LIFE CARE CENTER OF RENO	445 W. HOLCOMB LANE RENO, NV 89511

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F 000	INITIAL COMMENTS The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as the result of a complaint investigation conducted at your facility on 4/21/06 and finalized on 5/2/06 The following complaint was investigated Complaint # NV00011228 was a self reported incident of an injury to a resident caused by a staff member. The allegation of staff abuse was unsubstantiated. A deficiency was cited related to the facility's timeliness of identifying and investigating the cause of the resident's injury and alleged staff abuse.	F 000	This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of this Plan does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied.	6/16/06
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse,	F 225	F 225 I. Investigation of potential abuse was conducted regarding Resident #1. Facility unable to substantiate abuse. Resident is no longer in facility. II. Residents have the potential to be affected when reporting procedures are not followed. Nursing staff was educated on 5/8/06 regarding the importance of following Life Care Policy and Procedure regarding the appropriate reporting of allegations of abuse and or neglect. Nursing staff was also educated on the importance of explicitly reporting details, include timelines, when taking and writing statements.	

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MAY 17 2006
BUREAU OF LICENSURE AND CERTIFICATION
CARSON CITY, NEVADA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tomas Mann — TITLE: Executive Director — (X6) DATE: 5/17/06

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	Continued From page 1 including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on policy review, facility investigation review, interviews, and resident record review it was determined that the facility failed to ensure that allegations of staff mistreatment and an injury of unknown origin were reported immediately to the proper facility staff, that the alleged events were investigated promptly and thoroughly, and that the resident and other residents in the facility were protected from further potential abuse. Findings include: Review of the facility policy identified as Abuse, Mistreatment and Neglect stated that "Any form of	F 225	III. Facility staff will be in-serviced to reinforce Life Care's Policy and Procedure regarding reporting of abuse and neglect, treatment of residents and residents rights. Allegations of abuse or neglect will be reported to the Director of Nursing, Executive Director or their designee. Statements will be reviewed for appropriate timelines. IV. Director of Nursing, Executive Director or designee will review reports of alleged abuse or neglect to validate that the Life Care Policy and Procedure was followed. Findings and corrective measures will be reported to Performance Improvement Committee on a quarterly basis. V. Facility will be in substantial compliance by 6/16/06.	

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F 225	Continued From page 2 resident /patient abuse, mistreatment, or neglect will not be tolerated. It is the responsibility of all associated to report resident/patient abuse mistreatment or neglect directly to the director of nursing and/or the executive director or their designees. This policy described the steps to be followed. The policy stated that associates were to report any and all cases of suspected abuse, neglect and mistreatment. Nursing staff were to thoroughly examine the resident for signs of injury or abuse. The resident's condition, which included physical findings, vital signs and general condition would be charted for at least 72 hours. An incident was to be completed at the time of occurrence. This policy also stated that any associate suspected of resident abuse, mistreatment or neglect would be promptly relieved of duty until the investigation was complete. Resident #1: Record review of Resident #1 revealed that the resident had resided at the facility since July of 2002. The resident's diagnoses included senile demential and psychosis. The quarterly MDS (minimum data set) information, dated 3/20/06, revealed that the resident was identified with behaviors of persistent anger, verbal and physical abuse and resisted care, but who's negative mood could easily be altered. Record review revealed that on 2/10/06 Resident #1 exhibited behaviors of swearing and using foul language in front of other residents and staff and attempts to redirect would result in increased agitation. The resident refused to take	F 225		

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F 225	Continued From page 3 medication. The resident also attempted to kick, grab or hit staff, but physical behaviors were not directed to residents. The next entry stated that on 3/15/06 at 10:45 AM the resident pushed the bedside table causing it to fall down because the CNA (Certified Nursing Assistant) did not remove the table right away. Documentation on 3/17/06, at 1:00 AM revealed that the resident was yelling at a CNA and that the resident was complaining of pain in his/her left forearm. This was entered as a late entry, but it was not indicated if the date and time was the date and time of the occurrence or the late entry. The next entry was 3/17/06 at 3:08 PM. This entry indicated that the resident's right forearm was x-rayed because of pain and swelling. At 6:30 PM on 3/17/06, documentation revealed that the resident was identified to have had a non displaced distal ulnar (forearm) fracture. The physician and responsible party were notified and the resident was transferred to the hospital for treatment. Facility investigation review revealed that the initial investigation report included four staff statements which were all dated 3/20/06, which was a Monday. The statement from LPN (Licensed Practical Nurse) #1, dated 3/20/06 indicated no date of occurrence. The LPN wrote that a evening shift nurse asked if she had heard about Resident #1 or did the LPN see the resident's arm. Upon examination of the resident's right arm, there was swelling at the forearm and a brownish bruise to the posterior side of the forearm. The resident was asked what happened, to which the resident replied "They pulled me by my arm, it hurts." The physician and the family were notified, an x-ray of the resident's arm was done.	F 225		

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F 225	Continued From page 4 The statement from LPN #2 dated 3/20/06, stated that on Friday morning (no date) a CNA reported that the resident (Resident #1) was complaining of pain in the right hand. The resident was medicated for relief. When the nurse asked the resident what happened, the resident stated that a CNA grabbed his/her arm during care. The nurse documented that the resident was combative with staff. The statement from CNA #1 dated 3/20/06, stated that on Thursday (no date) the resident (Resident #1) was assisted with her care and had no voiced concerns. The statement from LPN #3 dated 3/20/06, stated that she was working with three CNAs (CNA #2, #3 #4) but did not indicate a date or time. LPN #3 did state that the resident (Resident #1) was exhibiting behaviors of screaming for staff to leave her alone and get out of her room. One CNA reported to LPN #3 that the resident had complained that "those girls handled me rough." The LPN was also informed that the resident was complaining of right forearm pain. The LPN stated that when she went in to assess the resident, the resident was asleep. The LPN did not wake the resident. The LPN also stated that she forgot to report the complaint to the day shift nurse. Subsequent interview statements were obtained by the facility on 3/20, 3/21 and 3/22. CNA #2's statement dated 3/21/06 indicated that on Thursday night shift (no date) the resident (Resident #1) was yelling and shaking the side rail. At 1:00 AM the resident was holding her right	F 225		

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F 225	Continued From page 5 arm and was complaining of pain. When asked what happened, the resident told the CNA that she was thrown like a rag doll when she was put into bed. The CNA went to get the nurse. CNA #3's statement dated 3/20/06, indicated that Resident #1 complained that her arm hurt. This was about 1:30-2:00 AM, but no date was indicated. When CNA #3 asked what happened to the resident's arm, the resident replied that someone was throwing her around in bed. CNA #3 stated that she attempted to find out who "someone" was by having the resident name or point out the person, but the resident only became more agitated. The statement from CNA #4 was dated 3/22/06. CNA #4 stated that she took care of the resident on Thursday evening (no date) and that the resident used her right arm to assist with turning by pulling herself over using the side rail. CNA #4 stated that the turning was done to the direction of the wall. An interview with LPN #1 on 4/21/06 at 9:00 AM revealed that Resident #1 had told her that "they were rough." The resident stated it was someone in Activities and then stated it was someone on nights. LPN #1 also stated after the resident's diagnosis of a fractured forearm occurred, the responsible party of the resident informed the facility that the resident had fallen out of her wheelchair while out with the responsible party. LPN #1 stated that this was not followed up to determine if the fall was before or after the fracture, or possibly the cause of the fracture. An interview on 4/21/06 with the DON (Director of Nursing) and ADON (Assistant Director of	F 225		

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F 225	Continued From page 6 Nursing) revealed that on 3/17/06, Resident #1 was diagnosed with a non-displaced fracture of the right forearm, but had no history of injury. The facility initiated the investigation of the fracture because it was an injury of unknown cause. This investigation was initiated on 3/20/06. The staff statements obtained during this investigation revealed that the resident had made allegations of staff mistreatment on the night shift of 3/16-17/06. The DON could not provide evidence that the alleged event was investigated before 3/20/06. The DON confirmed that the chain of reporting should have been from the resident to the direct care staff to the unit manager to the DON. The DON also stated that the staff should have contacted the DON at night to report a change in condition. An attempt to interview the resident was unsuccessful, because the resident was asleep. It was observed that the resident's bed was positioned in such a way that to turn the resident to the wall, the resident would have been turned to the left. The resident would need to use his/her right arm as described by CNA #4. Review of the facility investigations revealed that the statements by the staff did not indicate the date and time of their observations. The facility was not able to provide evidence that the resident was interviewed regarding her allegations. The facility was not able to provide any further information that the family was contacted to determine when the resident had fallen while out of the facility and in the care of the family member, and if the fall could have resulted in the forearm fracture.	F 225		

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F 225	Continued From page 7 The investigation did not provide any documentation why the investigation was not initiated on 3/17/06 regarding either Resident #1's allegations of staff mistreatment that were reported to LPN #3 or the subsequent identification of Resident #1's non-displaced fracture of her right forearm as an injury of unknown origin. The investigation did not indicate that staff were in-serviced, counseled or reprimanded except for a comment written on the statement by LPN #3 which read that the DON informed LPN #3 that an immediate assessment and investigation would be appropriate in the future. The investigation did not provide any evidence that Resident #1 was protected from mistreatment during the time of the initial allegation Thursday night (3/16/06) to the completion of the investigation on Wednesday (3/22/06).	F 225		